Continence Screening Form

ID LABEL

To be completed by Family prior to admission

Bladder Health

Date:____/____/____

1. Does the resident go to the toilet more than 6 times In the day to pass urine?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

2. Does the resident get up more than once during the night to pass urine?
   - ☐ No
   - ☐ Don't know

3. Does the resident leak urine?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

4. Does the resident have any other bladder problems (ie. Difficulties passing urine and/or pain)?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

Bowel Health

5. Has the resident lost control of or leaked bowel motions?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

6. Does the resident have any bowel difficulties (ie. Constipation or diarrhoea)?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

Pad Usage

7. Does the resident wear pads?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

8. Does the resident have to change his/her Underclothes or wear protection because of bladder or bowel leakage or soiling?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

If you ticked YES or DON'T KNOW to any of theses questions, please:

- Complete Bladder Chart and Bowel Chart